PATIENT HISTORY FORM

GENERAL INFORMATION

PATIENT'S NAME _____ **AGE** _____ **SEX** _____ **DATE** _____

PARENT _____ **PHONE** _____

ADDRESS _____ **OCCUPATION** _____

REFERRED BY _____

MEDICAL INFORMATION

A. CHIEF COMPLAINTS:

List each complaint and when it started.

1. _____
2. _____
3. _____
4. _____
5. _____

B. GENERAL SYMPTOMS:

1. POLLEN ALLERGY SYMPTOMS:

Check line beside symptom

___ Worse outdoors
___ Worse on windy days
___ Worse on clear days
___ Worse outdoors 7 to 11 a.m.
___ Worse in change of temperature
___ Worse in warm or cool air
___ Better indoors
___ Better outdoors

2. DUST ALLERGY SYMPTOMS:

Are your symptoms?

___ Worse indoors
___ Better outdoors
___ Worse 30 minutes after retiring
___ Worse in cold weather
___ Worse when sweeping
___ Worse when dusting

3. MOLD ALLERGY SYMPTOMS:

Are your symptoms?

___ Worse outdoors from 4 to 9 p.m.
___ Worse on cool evenings
___ Worse in low, damp place
___ Worse mowing or playing in grass
___ Worse on windy days

4. CONTACT ALLERGY SYMPTOMS:

Are your symptoms?

___ Worse after lights are on 1 hour
___ Worse in certain rooms
Which one _____
___ Worse in basement
___ Worse near a barn
___ Worse around animals
Which ones _____

5. Are your symptoms constant or intermittent? _____

6. During what months do you usually have symptoms:

___ January
___ February
___ March
___ April
___ May
___ June
___ July
___ August
___ September
___ October
___ November
___ December
___ All Months

7. During what months are symptoms most severe?

___ January
___ February
___ March
___ April
___ May
___ June
___ July
___ August
___ September
___ October
___ November
___ December
___ All Months

8. How and when did this condition begin? _____

_____

_____

C. MEDICAL HISTORY

1. What prescription and non-prescription medications do you take?

___ Aspirin
___ Cortisone
___ Tranquilizers
___ High Blood Pressure Medication
___ Sedatives
___ Birth Control
___ Antibiotics
___ Vitamins
___ Ointments
___ Thyroid Medication
___ Nose Drops/Sprays
___ Hormones
___ Antihistamines
___ Decongestants
___ Anticholesterol Drugs (Cholestyramine)

List Others: _____

_____

_____

_____

2. What medications relieve your allergy symptoms? _____

_____

3. Check the following medical conditions you are experiencing or have experienced in the past:

___ High Blood Pressure
___ Thyroid Disfunction
___ Seizures
___ Bronchitis
___ Skin Disease
___ Sinus Disease
___ Nasal Surgery
___ Stomach or Intestinal Disease
___ Heart Disease
___ Arthritis
___ Asthma
___ Hay Fever
___ Drug Allergy
___ Nasal Polyps
___ Milk Allergy
___ Frequent Headaches
___ Migraine Headache
___ Croup
___ Emphysema
___ Hives
___ Colitis
___ Broken Nose
___ Ulcers
___ Deviated Septum

Smoking Habits:

Cigarettes #_____/day
Pipe #_____ /day
Cigars #_____ /day
Years Smoked _____
Stopped Smoking in 19_____

Check the following that apply:

___ Family Problems
___ School Problems
___ Frequently Absent From School/Work
___ Over-anxious
___ Divorced
___ Separated

4. List all surgeries and hospitalizations:

Date	Type of Surgery	Reason

5. List physicians you have consulted in the past 5 years for allergy or other medical problems:

Name	Address/Phone	Reason

D. FAMILY HISTORY

Circle all relatives who have allergic symptoms as described under chief complaint (Refer to Page 1). Give cause of allergy when known.

Father	Brother 1.	Sister 1.	Son 1.	Daughter 1.
Mother	Brother 2.	Sister 2.	Son 2.	Daughter 2.

Father's Side of Family

Grandfather
Grandmother
Uncle
Cousin
Great Grandfather
Great Grandmother
Aunt

Mother's Side of Family

Grandfather
Grandmother
Uncle
Cousin
Great Grandfather
Great Grandmother
Aunt

SYSTEMS REVIEW

A. GENERAL

1. Nose:
___ Stuffy
___ Runny
___ Itching

2. Ears:
___ Stopped up feeling
___ Itching
___ Sore

3. Nasal Blocking:
___ Alternating from one side to the other
___ Constant
___ Night, what time _____
___ Day, what time _____
___ After meals, how long _____
___ Year round
___ Seasonal, which _____

4. Mouth:
___ Roof itch
___ Tongue coated
___ Ulcerated
___ Lips swell
___ Throat itch

5. Eyes:
___ Water
___ Itch
___ Swelling
___ Burn

6. Cough:
___ Year round
___ Seasonal
___ Daytime a.m.____p.m.____
___ Worse after a cold

7. Itching:
___ Eyes
___ Ears
___ Between shoulders
___ Throat
___ Feet
___ Hands

Worse in:
___ Winter
___ Spring
___ Summer
___ Fall

8. Sneezing:
___ Year round
___ Seasonal
___ In early a.m.
___ At meal time
___ 30 minutes after eating
___ Smoky places
___ Dust

9. General Symptoms:
___ Pain, where _____
___ Nose bleed
___ Weight loss
___ Tire out easily
___ Cannot sleep
___ Night sweats
___ Temperature
___ Sore throats often
___ Colds frequently

B. STOMACH AND INTESTINES

1. **Appetite:** Good _____ Picky _____ Poor _____
2. **Bowels:** Regular _____ Constipated _____
3. **Stools:** Diarrhea _____ Solid or mucus _____ Normal _____
4. **MOUTH:**
   - ___ Offensive breath
   - ___ Swallowing difficulties
   - ___ Sores

STOMACH:
- ___ Choking feeling
- ___ Nausea
- ___ Vomiting
- ___ Bloating
- ___ Retasting
- ___ Gas
- ___ Indigestion

RECTUM:
- ___ Irritated
- ___ Raw
- ___ Pain

C. HEART AND ARTERY

1. **Labored Breathing**
   - ___ Day
   - ___ Night
   - ___ Use pillows
   - ___ How many
   - ___ After exercise
2. **Weight Loss:**
   - ___ How much
   - ___ Dieting
   - ___ Diet pills
   - ___ Do diuretics help
3. **Pain in Chest**
   - ___ From exercise
   - ___ Difficult breathing
   - ___ Stationary
   - ___ Radiates
4. **Swelling:**
   - ___ Legs
   - ___ Feet
   - ___ Hands
   - ___ Eyes

   Time of day a.m. _____ p.m._____

D. NEUROLOGICAL AND SKELETAL

1. **Headaches:** How long_____ Onset _____ Regular _____ Periodic _____ Irregular _____
2. **Where Does It Hurt?** _____
3. **Cerebral:** Ringing noises _____ Dizzy _____ Psychosomatic _____
4. **Joint Pains:** Which one _____ How often _____
5. **Muscular Pains:** Where _____
6. **Bursitis:** Where _____
7. **Arthritis:** Where _____

E. SKIN

1. **Sores:** Kind _____
2. **Hives:** _____
3. **Rash:** What type _____ Where _____

F. GENITOURINARY

1. **Urination**
   - ___ Painful
   - ___ Delayed
   - ___ Frequent
   - ___ Prolonged
   - ___ Normal
   - ___ Bed Wetting
   - ___ Infections Day _____ Night _____

ENVIRONMENTAL EXPOSURES

A. HOME

a. Type
- Single house _____
- Duplex _____
- Apartment, floor _____
- Hotel _____
- Trailer _____

b. Details
- Slab or Piling foundation _____
- Age of house _____
- Sheet rock or papered walls _____
- Occupancy since _____

c. Region:
- City, industrial _____
- City, residential _____
- Suburban _____
- Small town _____
- Rural _____

d. Garage attached to house?
Yes _____ No _____

e. Heating and ventilation:
- Central Heat – Gas or Electric _____
- Central Air – Gas or Electric _____

f. Washer and Dryer:
- Location _____
- Gas or Electric _____

g. Hot Water Heater
- Location _____
- Gas or Electric _____

h. Houseplants _____
- Location _____
- Type _____

B. CHEMICALS IN HOME USE (Indicate brand name)

Roach chemical	Ant chemical	Chlorine cleansers	Household cleaners	Air fresheners	Aerosols
_____	_____	_____	_____	_____	_____

C. COSMETICS (Indicate brand name)

Bath powder	Bath soap	After shave	Mascara	Tooth paste	Shampoo	Hair conditioner
Hair coloring	Perfume (or cologne)	Shaving cream	Cold cream	Deodorant	Washing detergent	Fabric softener

D. ANIMALS AND BIRDS (Indicate type)

Dog (inside or outside)

Cat (inside or outside)

Birds (parakeets, finches, etc.)

Gerbils, hamsters, mice, etc.

Feather pillows? _____ Yes _____ No

Down jackets, comforters, sofas, etc.?

Mattress & Springs – Age and Type

E. CHECK ANY OF THE FOLLOWING THAT AGGRAVATE YOUR SYMPTOMS:

1. ___Paint fumes 2. ___Mowing lawn 3. ___Smoke 4. ___Cooking odors 5. ___Newspapers 6. ___Road dust 7. ___Air pollution 8. ___Wool

DIETARY HABITS

Please review each food individually for average frequency of ingestion and mark as follows: D – Daily, F – Frequently (at least every 4 days), S – Sometimes (once every 1-2 weeks), R – Rarely, N – Never. Be sure to include ingredients in food mixtures such as: milk and egg in cookies, wheat in bread, soy in hamburger meat, etc.

A. VEGETABLES

Asparagus	___	Lettuce	___
Beans, lima	___	Mushroom	___
Beans, navy	___	Mustard Greens	___
Beans, string	___	Okra	___
Beets	___	Onion	___
Broccoli	___	Parsnip	___
Brussels Sprouts	___	Peas, green	___
Cabbage	___	Peas, blackeye	___
Carrots	___	Potato, sweet	___
Cauliflower	___	Potato, white	___
Collards	___	Potato chips	___
Corn	___	Radish	___
Celery	___	Soybean	___
Cucumber	___	Spinach	___
Eggplant	___	Squash	___
Garlic	___	Tomatoes	___
		Turnips	___

B. FRUITS

Apple	___	Lemon	___
Apricot	___	Lime	___
Avocado	___	Olive	___
Banana	___	Orange	___
Blackberry	___	Peach	___
Cantaloupe	___	Pear	___
Cherry	___	Pineapple	___
Cranberry	___	Plum	___
Date	___	Prune	___
Fig	___	Raspberry	___
Grape	___	Rhubarb	___
Grapefruit	___	Strawberry	___
		Watermelon	___

C. VITAMINS

Complex	___
B-12	___
Vitamin C	___

D. CEREALS

Arrowroot	___
Barley	___
Cornmeal	___
Oats	___
Rice	___
Rye	___
Tapioca	___
Wheat (bread)	___

E. NUTS

Almond	___
Brazil Nuts	___
Cashews	___
Coconut	___
Hazelnut	___
Peanut	___
Pecan	___
Pistachio	___
Walnut, black	___
Walnut, english	___

F. CONDIMENTS

Black Pepper	___
Cinnamon	___
Cloves	___
Ginger	___
Nutmeg	___
Paprika	___
Pimento	___
Sage	___
Vanilla	___
Yeast, baker's	___
Yeast, brewer's	___

G. MEATS, FISH, POULTRY, & DAIRY

Beef	___	Milk	___
Catfish	___	Pork	___
Chicken	___	Rabbit	___
Duck	___	Salmon	___
Egg	___	Tuna	___
Gelatin, Knox	___	Trout	___
Shrimp	___	Turkey	___
Jello	___	Veal	___
Lamb	___	Crab	___
Liver			

H. BEVERAGES

Chocolate	___
Coca-Cola	___
Coffee	___
Dr. Pepper	___
Tea	___
Beer	___
Whiskey	___
Diet Colas	___

I. MISCELLANEOUS

Cottonseed (Wesson Oil)	___
Safflower Oil	___

Any additional relevant information? _____